CSH SIF Classic

Developing housing and health care solutions for vulnerable populations

Homelessness and High-Cost Use of Crisis Health Services

Problem… Subset of individuals who cycle between multiple crisis systems, use a disproportionate share of healthcare costs and are systematically excluded from interventions that may benefit them

- Lack of care coordination and connection to primary/preventive services, which leads to frequent use of crisis health services
- High costs and poor outcomes for individuals… multiple arrests, risky behaviors, unmanaged chronic conditions
- Funding and policymaking in “silos” prevents the provision of integrated solutions that address health, social, and housing needs at once

Solution… Supportive Housing as a Platform for a Coordinate Service Delivery System

- Population demands a more comprehensive intervention: targeted housing, enhanced outreach and engagement, intensive case management
- Use data to identify and target cohort
- Builds integration with health care improving health access, improve health outcomes and better utilizes public resources

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Theory of Change

Tenants are homeless, have complex health conditions and not well connected to a medical home

Supportive Housing

Prioritization and Placement in Housing

Troubleshooting of Housing Problems / Lease Violations

Stable housing creates platform for confronting health needs and receiving care

Care Management and Patient-Centered Health Home

Engagement and Rapport Building → Motivational Enhancement & Empowerment → Care Management and Coordination → Coordinated Primary/ Behavioral Health Care

Health status improves, use of crisis health services decreases, use of preventive care increases, and public costs lowered or offset

Why Target Frequent Users?

Homelessness with Complex Needs and High Costs

- Subset of individuals who cycle between multiple crisis systems and are systematically excluded from interventions that may benefit them.
- Poor outcomes for individuals… multiple arrests, risky behaviors, unmanaged chronic conditions
- High costs with little positive results

Opportunity for Coordinated Service Delivery System with In Supportive Housing

- Population demands a more comprehensive intervention: targeted housing, enhanced outreach and engagement, intensive case management, and access to health care
- Use data to identify and target cohort
- Builds integration with health care improving health access and outcomes while lowering costs

Blue Print for Systems Change and Scaling

- Develop a services financing model that benefits all systems
- Diversify funding for services and reinvest savings from health/CJ system into housing and/or housing based services
- Increase capacity of housing and services interventions to end chronic homelessness!

Evaluation Design

Researchers from NYU's School's of Medicine and Education are completing a cross-site, multi-method evaluation to measure the impact on health and housing stability, use of crisis health services and Medicaid and other public costs

Key Research Questions

- Is it possible to effectively target and engage the kinds of homeless high utilizers for whom this program was intended and provide them with the type of supportive housing that was thought likely to be effective?
- If so, would we see impacts on health care utilization – that is reductions beyond what likely would have happened even without the program? What about impacts on shelter use and jail time?
- Would these impacts prove sufficient to cover the costs of the program?

Methods:

- Site visits
- Participant Survey Data
- Administrative health, homelessness and jail utilization data

Adapting Supportive Housing as a Health Care Intervention

Data Driven Targeting

Assertive Outreach and Housing First

Patient Navigation/Health Care Coordination

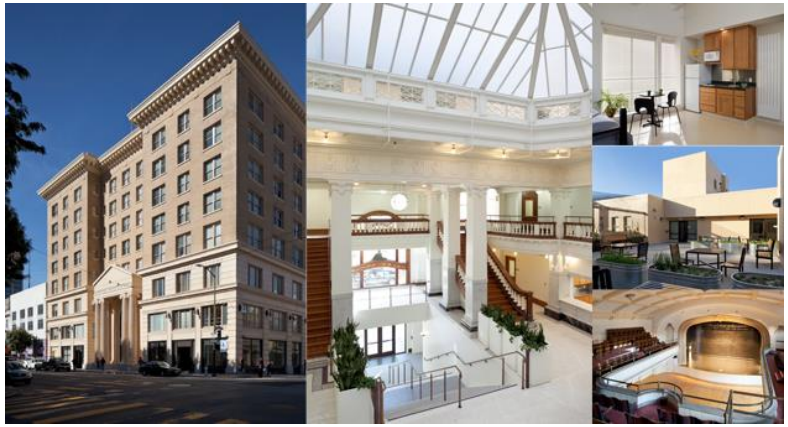
Clinical Partnerships with Health Care Providers

SIF uses 2 types of data driven targeting….

- Match identified administrative data from HMIS and health system (Medicaid/hospital) to generate list of priority individuals
  - Engaged only those on the list who meet threshold criteria
  - Criteria can be adjusted based on local characteristics and need

- Point of Care: Use de-identified administrative data to develop predictive algorithms
    - Able to identify and engage high utilizers in multiple systems (hospitals) and make direct referrals to housing
    - In LA, the 10th Decile Triage tool is used in 14 hospital systems

Lead Organization	Tenderloin Neighborhood Development Corporation	AIDS Connecticut	Housing Works, HHCLA, Acencia, OPCC	Avalon Housing
Target Geography	San Francisco, CA	Connecticut (statewide)	Los Angeles County, CA	Washtenaw County/Ann Arbor, MI
Number of Individuals	172	160	107	110
Data Driven Approach to Client Identification	Analysis of ED/hospitals records & top 200 users of county health plan services	Data match between Medicaid and HMIS to identify top 10% highest users	Predictive algorithm to identify highest decile of costs of crisis health service use	County health plan data analysis to identify highest cost users
Outreach and Recruitment	In-reach into hospitals and emergency rooms	In-reach into hospitals and shelters	Hospital-based screening	In-reach into emergency rooms and hospitals
Housing Model	Single-site supportive housing building (with onsite FQHC)	Scattered-site and single-site	Single-site and scattered-site	Scattered-site
Primary and Behavioral Health Services	City of San Francisco Housing and Urban Health FQHC	Five regional partnerships between FQHCs and LMHAs	Several FQHCs	University of Michigan Hospital and Packard Health
Integration of Health and Housing	Integrated services team between TNDC and HUH	FQHC-based patient navigators/boundary spanners	Patient navigators/system coordinators	Integrated Housing and Health Care Team

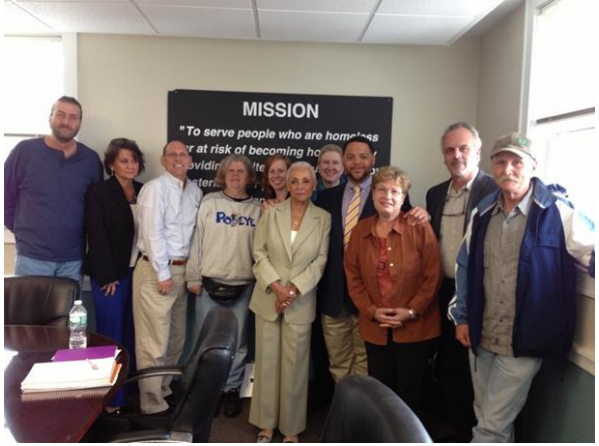


Kelly Cullan Community Center

Target: 172

Partner Agencies
TNDC, SF Department of Health, SF Health Plan, Lutheran Social Services, YMCA

- Co-located FQHC and Supportive Housing
- Housing first approach with assertive outreach and engagement
- Intensive case management, comprehensive needs assessment and individualized service planning
- Housing stabilization, retention, and eviction prevention
- Nurse case management and medication adherence assistance
- Coordinated primary and behavioral health care
- Community building and social activities



State of CT

Target: 160

Administrative data match b/w Medicaid and HMIS to identify the target population

Non-profit Housing & Service Providers

- Columbus House, New Haven
- Journey Home, Hartford
- New London Homeless Hospitality Center
- Supportive Housing WORKS, Bridgeport

Integrated Health Partners:

Community Health Network of CT, ValueOptions, FQHCs and Local Mental Health Authorities

Housing Resources:

Governor's office allocated 150 Rental Assistance Program vouchers

Programmatic Highlights…

- Successful public/private partnership with $13 million in match funds raised
- 47% engaged at hospital or health clinic
- 719 people housed
- 89% housing retention rate
- 92% report being connected to primary health care services

What are we learning so far…

1. Data driven targeting is effective in **defining *and* locating** the highest utilizers with complex needs. Integrating data to see people beyond our "own" system

2. Forging new institutional and cross-agency partnerships…
   - Leveraged housing resources including 150 state vouchers from CT and set-aside of units from Ann Arbor Housing Commission
   - Cross system case conferencing and Interagency Steering Committee to monitor progress and overcome system barriers in real time
   - *Avoid duplication or temptation to build from scratch… leverage the strengths of the right system/agency/staff to play the right role (SH and health)*
   - Aligning priorities: health systems focus on super utilizers homeless system focus on ending chronic homelessness

3. Effective engagement requires housing first approach, flexibility and partnerships
   - Intensive Service Model and Small Case Loads: 10:1
   - ***The Role of the Patient navigator is Key***… Relationships that extend beyond housing and health care…
   - Coping with complex health issues and even death (13 people have died across all sites)

4. Role of community context and resources in program implementation and impact

5. Impact of supportive housing as a health care intervention for those with greatest cost and complex chronic conditions

Early Evaluation Results

Administrative data shows high utilization at baseline:

In the year prior…

- Average hospitalizations: 2.3
- Average number of hospital days: 21.4 (> 30 in CT, ~9 in MI, and ~ 12 in SF)
- Average ED visits: 9.3
- High average costs of healthcare

  ~ $30,000 in MI and SF

  ~ $60,000 in CT

In the 12 month follow up period:

- SF: reduction in hospital days (-5) and number of medical hospitalizations (-1)
- CT: reduction in hospitalizations (-1.1) and a cost reduction of $15,583

Key Takeaways…

- It is possible to develop and deliver a medically-oriented supportive housing program targeted at homeless individuals who are high utilizers of health care, but it is difficult. Program implementation and capacity for impact are both influenced by local context and state policy

- This program can reduce utilization of shelters and costly health care, primarily through reduced hospitalizations, and especially for those who were mostly costly at baseline. These reductions can substantially offset program costs.

- While the program was associated with reduced costs and utilization and improvements in self-reported quality of life and access to care, many participants were still likely experiencing deep and complex health problems one year into the program.

Sustaining and scaling take both practice and policy reform

Utilizing both state and federal resources, engaging health systems, MCOs, Medicaid directors to discuss role housing can play in reducing healthcare costs

California

- Increased **investments** for health and housing integration:
  - LA County Healthcare investments by DHS, MCOs, DHCS for integrated services:
    - Whole Person Care (Medi-Cal waiver); L.A. Care investment in Flexible Housing Subsidy Pool; and Health Home
  - LA County Homelessness Initiative:
    - Measure H funding and Proposition HHH

Connecticut

- Continued state investment through housing vouchers and DMHAS service dollars
- 1915i Policy Development
- Hospital Engagement/Community Care Teams (CCT)
- Medicaid Institute for SH Agencies

Washtenaw

- Lead Agency Transitioned to Medicaid Biller
- Integration of FUSE into CA
- Engagement of State and Interagency Committee

Evaluation

- Closer look at changes in hospitalization (funded)
- Quality of care
- Jail data
- Mortality

Scaling with PFS and Common Elements

- Partners identify a concrete problem/goal and a proven solution.
- Data is used to understand and identify a target population and targeted outcomes are identified.
- Intervention is designed that will meet the needs of the target population and achieve the targeted outcomes.
- Resources and funding are identified to implement.
- Proven, high capacity housing and service providers are identified.
- Eligibility, enrollment and evaluation strategies are designed and implemented.
- Implementation occurs and adjustments are made along the way.